Administrative Code

Title 23: Medicaid
Part 214
Pharmacy Services

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Title 23: Division of Medicaid

Part 214: Pharmacy Services

Part 214 Chapter 1: General Pharmacy

Rule 1.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers in addition to the provider type specific requirements that follow:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Written confirmation from the IRS confirming the tax identification number and legal business name, and

3. Copy of current pharmacy permit issued by the Mississippi Board of Pharmacy.

B. Participation as a pharmacy provider in the Medicaid program is limited to:

1. Pharmacies with a MS Board of Pharmacy permit for specified types of pharmacies:

a) Retail pharmacy must hold a community pharmacy permit,

b) Closed-door pharmacy must hold a specialty community pharmacy permit, and

c) Institutional pharmacy must hold an Institutional I or Institutional II pharmacy permit.

2. Pharmacies located physically within the state of Mississippi or within a thirty (30) mile radius of the state borders. Exceptions to the thirty (30) mile limit may be made if the servicing pharmacy provider is:

a) Providing drugs to a Mississippi Medicaid beneficiary who is a resident of a nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or psychiatric residential treatment facility (PRTF) or receiving specialized care, that is located outside of the thirty (30) mile radius, or

b) The pharmacy provider is the source of a drug not obtainable from any pharmacy provider within the state or the thirty (30) mile radius.

C. Medicaid reimburses pharmacy providers only for prescriptions that are received via hand delivery by a beneficiary or his/her representative, received directly via phone, fax, mail or other electronic means such as e-mail or electronic prescribing from a prescribing provider licensed under State law or an agent with medical training under the health professional's

direct supervision. Refer to Part 214, Rule 1.6 for prescription requirements.

D. For Change of Ownership Liability Refer to Part 200, Chapter 4, Rule 4.3.

Source: Miss. Code Ann. § 43-13-121; § 73-21-105; 73-21-106

Rule 1.2: Pharmacy Services

Medicaid covers all prescription drugs manufactured by a company that has signed a drug rebate agreement, with certain specific exceptions. Medicaid is not required to cover prescription drugs from manufacturers that do not participate in the federal drug rebate program.

Source: Miss. Code Ann. § 43-13-121; Deficit Reduction Act (DRA) of 2005; 42 USC 1396b(i); 42 USC § 1396r8(a)

Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted

A. Medicaid does not cover pharmacy benefits for full benefit, dual eligible individuals who are entitled to receive Medicare benefits under Part A, B, or C, except for drugs in the Medicare excluded categories.

B. Excluded or otherwise restricted drugs include, but are not limited to:

1. Drugs when used for anorexia, weight loss, or weight gain are excluded,

2. Drugs when used to promote fertility are excluded,

3. Drugs when used for cosmetic purposes or hair growth are excluded,

4. Over-the-counter (OTC) items other than those listed on Medicaid's OTC formulary. These items are covered only if they contain an appropriate National Drug Code (NDC) on their label and are manufactured by a company that has signed a rebate agreement are restricted.

5. Drugs when used for the symptomatic relief of cough and colds,

6. Prescription vitamins and mineral products except for:

   a) Prenatal vitamins for women up to age forty-five (45),

   b) Folic acid,

   c) Cyanocobalamin (vitamin B_{12}) injections, and

   d) Certain renal vitamins for dialysis patients which must have "for dialysis" written on

the prescription by the prescriber.

7. Covered outpatient drugs which the manufacturer requires, as condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee are excluded,

8. Those drugs designated less than effective by the Federal Drug Administration (FDA) as a result of the Drug Efficacy Study Implementation (DESI) program unless provided through expanded EPSDT services in Part 223, Chapter 1, Rule 1.7 are excluded.

9. Benzodiazepines except generic formulations are restricted,

10. Barbiturates except Phenobarbital and Mephobarbital are restricted,

11. Drugs used to treat erectile dysfunction are excluded,

12. Drugs that are investigational or approved drugs used for investigational purposes are excluded,

13. Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature are restricted,

14. Drugs dispensed after the expiration date are excluded,

15. Drugs classified as herbal and/or homeopathic products are excluded,

16. Cost of shipping or delivering drugs are excluded,

17. Drugs produced by manufacturers that do not have signed rebate agreements with the federal government as required by OBRA'90 unless provided through expanded EPSDT services in Part 223, Chapter 1, Rule 7.1 are excluded, and

18. Compounded prescriptions except for hyperalimentation. Medicaid defines compounded prescriptions as mixtures of two or more ingredients are restricted.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 423.772; 42 CFR 423.906(c); 42 CFR 423.100; 42 U.S.C. 1396r-8(d); 42 USC 1396r-8(a)(7)(c); Social Security Act, Section 1935(d)(2); 1927(d)(2);

Rule 1.4: Prior Authorization

Medicaid requires prior authorization of certain covered drugs to ensure use as approved by the Food and Drug Administration (FDA) for specific medical conditions.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(A)(9); § 73-21-129; 42 USC 1396r-8(d)(5)

Rule 1.5: Reimbursement

A. Medicaid reimbursement for covered brand name and single source generic drugs is:

1. The lesser of:

   a) The usual and customary charge, or

   b) The Federal Upper Limit (FUL), if applicable, and a dispensing fee of three dollars and ninety one cents ($3.91), or

   c) Average Wholesale Price (AWP) less twelve percent (12%) and a dispensing fee of three dollars and ninety one cents ($3.91), or

   d) Wholesale Net Unit Price/Wholesale Acquisition Cost (WAC) plus nine percent (9%) and a dispensing fee of three dollars and ninety one cents ($3.91). Wholesale Net Unit Price (WNUP) is the published unit price that a manufacturer charges a wholesaler, commonly referred to as the Wholesale Acquisition Cost (WAC).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines brand name drugs as single source or innovator multiple source drugs.

4. Medicaid defines single source generic drugs as those drugs going off patent and a single source generic house has exclusivity for a period of time.

B. Medicaid reimbursement methodology for multiple source generic drugs is:

1. The lesser of:

   a) The usual and customary charge, or

   b) The Federal Upper Limit (FUL), if applicable, and a dispensing fee of four dollars and ninety one cents ($4.91); but note, the dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to three dollars and ninety one cents ($3.91), or

   c) Average Wholesale Price (AWP) less twenty five percent (25%) and a dispensing fee of four dollars and ninety one cents ($4.91); but note, the dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

C. Medicaid reimbursement methodology for covered over-the-counter (OTC) drugs is:

1. The lesser of:

a) The usual and customary charge, or

b) The estimated shelf price and a dispensing fee of three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines estimated shelf price as the lowest of the following:

a) Mississippi Estimated Acquisition Cost (MEAC) for OTC drugs is defined as the Average Wholesale Price (AWP) less twenty five percent (25%), or

b) Federal Upper Limit (FUL) is the unit price as published by the Centers for Medicare and Medicaid Services (CMS).

D. Medicaid does not reimburse claims at more than the usual and customary charge. Claims must be billed at the usual and customary charge. Medicaid defines usual and customary charge for prescription drugs as the price charged to the general public. Medicaid defines the general public as the patient group accounting for the largest number of non-Medicaid prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through a third party payer.

Source: Miss. Code Ann. § 43-13-121; Section 1902(a)(30)(A) of the Social security Act.; 42 CFR 447.332.; § 73-29-155

Rule 1.6: Prescription Requirements

A. Pharmacists in the legal employ of the pharmacy provider or under the personal direction of a pharmacist employed by the pharmacy provider must submit claims for services rendered. Prescriptions must be dispensed at the provider's actual physical location of the pharmacy.

B. For purposes of this rule, Medicaid defines a prescribing provider as one who is duly licensed and is acting within the scope of practice of his/her profession according to State law.

C. All non-electronic prescriptions must be written on tamper-resistant pads/paper in order to be eligible for reimbursement by Medicaid.

1. The tamper-resistant prescription pads/paper requirement applies to all Medicaid prescribing providers including physicians, dentists, optometrists, nurse practitioners and other providers who prescribe outpatient drugs including over-the-counter drugs.

2. Exemptions to this mandate include:

   a) Prescriptions presented by other modes of transmission including facsimile, electronic or e-prescribed, and telephone,

   b) Written orders prepared in an institutional setting, including intermediate care facilities and nursing facilities, provided that the beneficiary never has the opportunity to handle the written order and the order is given by licensed staff directly to the dispensing pharmacy, or

   c) Transfer of a prescription between two (2) pharmacies, provided that the receiving pharmacy is able to confirm by facsimile or telephone call the authenticity of the tamper-resistant prescription with the original pharmacy.

D. The pharmacy provider must ensure the integrity of telephone, electronic and/or faxed prescriptions.

E. All Medicaid beneficiaries are limited to five (5) prescriptions per month, including refills, with no more than two (2) being brand name drugs, unless provided through expanded EPSDT services in Part 223, Chapter 1, Rule 1.7 or to long-term care residents.

F. Medicaid requires that all drugs be prescribed in a full month's supply which may not exceed a thirty one (31) day supply. The following exceptions are allowed:

1. Drugs in therapeutic classes commonly prescribed for less than a month's supply including, but not limited to, antibiotics and analgesics,

2. Drugs that, in the prescribing provider's professional judgment, are not clinically appropriate for the beneficiary to be dispensed in a month's supply,

3. Drug products where the only available package size of the product is one that exceeds the thirty one (31) day supply limit,

4. Certain drugs issued by the Mississippi Department of Health (MSDH) and approved by Medicaid, including, but not limited to:

   a) Contraceptives which may be dispensed in a one (1) year supply.

   b) Tuberculosis (TB) medications which may be dispensed in a three (3) month supply.

5. Six (6) vials, sixty (60) ml each, of insulin may be dispensed at one time,

6. Oral contraceptives may be dispensed in three (3) month supplies,

7. Prenatal vitamins may be dispensed in three (3) month supplies,

8. Those products with cumulative maximum daily and/or monthly units as recommended by the Food and Drug Administration (FDA) and the manufacturer, and/or as recommended by the Drug Utilization Board and approved by Medicaid,

9. Those products limited by authority of Medicaid with the potential for misuse, abuse, or diversion for the public safety, well-being and/or health, or

10. A limited listing of maintenance medications, approved by Medicaid, which may be dispensed in no more than a ninety (90) day supply.

G. In emergency situations, Medicaid will reimburse for a seventy two (72) hour supply of drugs that require prior authorization.

H. Pharmacy claims must be billed using the National Drug Code (NDC) number of the product dispensed. Pharmacy providers must bill the eleven (11) digit NDC for the drug and package size actually dispensed. This requirement is for all products, regardless of legend or over-the-counter (OTC) status.

Source: Miss. Code Ann. § 43-13-121; § 73-21-115; 42 USC 1396b (i) (21) and (23); 42 USC 1396br-8(a) and (d); 42 USC 1903(i)(23); Social Security Act,

Rule 1.7: Refills/Renewals of Prescription Drugs

A. A written, faxed, e-prescribed, or telephoned prescription may be refilled, in compliance with the prescriber's order, up to a limit of eleven (11) times per year, if compliant with state and/or federal regulations and guidelines. Additionally, the following are applicable:

1. The absence of an indication to refill by the prescribing provider renders the prescription non-refillable.

2. Refills are reimbursable only if specifically authorized by the prescribing provider.

3. Medicaid does not reimburse for prescription refills that exceed the specific number authorized by the prescribing provider.

4. Medicaid does not reimburse for any refills dispensed after one (1) year from the date of the original prescription.

5. Medicaid does not reimburse for a prescription refill with greater frequency than the approximate interval of time that the dosage regimen of the prescription would indicate, unless extenuating circumstances are documented which would justify the shorter interval of time before the refilling of the prescription.

6. Medicaid does not reimburse for quantities in excess of the prescribing provider's

authorization.

B. Medicaid does not reimburse for any refill without an explicit request from a beneficiary or the beneficiary's responsible party, such as a caregiver, for each filling event. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

C. Medicaid beneficiaries or providers cannot waive the explicit refill request and enroll beneficiaries in an electronic automatic refill in pharmacies.

D. Medicaid does not reimburse for a prescription refill until seventy five percent (75%) of the day's supply of the drug has elapsed as indicated on the prescription.

1. For any controlled substance (Schedule III, IV, and V), Medicaid does not reimburse for a prescription refill until eighty five percent (85%) of the day's supply of the drug has elapsed as indicated on the prescription. Any attempt to refill a prescription through the Point-of-Sale system before the twenty-sixth (26^{th}) day will be automatically denied.

2. By law, Schedule II narcotics cannot be refilled.

E. As long as the monthly service limits have not been exhausted, Medicaid may permit an early refill of an original claim under one (1) of the following circumstances:

1. The client's life is at risk,

2. When an acute clinical condition is occurring, which would require extra medication to stop or mitigate further morbidity, or

3. The prescribing provider either increases the dosing frequency or increases the number of tablets per dose. The prescribing provider must document the change in dosage or frequency by writing or phoning in a new prescription. The prescriber(s) who wrote the original prescription must initiate any request for additional medication.

F. Medicaid does not generally reimburse for replacement of prescriptions that are lost, stolen or otherwise destroyed.

1. Replacement of prescriptions is the beneficiary's responsibility.

2. If a beneficiary requires an early refill, the prescribing provider must request an exception override of this requirement by seeking approval from Medicaid's Pharmacy Bureau Prior Authorization (PA) Unit.

Source: Miss. Code Ann. § 43-13-121

Rule 1.8: Generic Mandates for Prescription Drugs

Mississippi law requires that Medicaid does not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive.

A. Generic drugs classified as non-preferred by Medicaid require prior authorization.

B. In the absence of a specific request for the brand name drug from the prescribing provider to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent unless the branded agent is preferred and the generic agent is non-preferred.

C. Prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except Narrow Therapeutic Index (NTI) drugs as defined by Medicaid.

Source: Miss. Code Ann. § 43-13-117; § 73-21-115; 73-21-117; 73-21-123; 73-21-127; 73-21-129

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Preferred Drug List

A. The Division of Medicaid recommends that prescribers use the drugs on the Preferred Drug List (PDL).

    1. The PDL is defined as a list of drugs reviewed and proposed by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, nurse practitioners, and/or other health care professionals. Final approval of the PDL is the responsibility of the Executive Director of the Division of Medicaid.

    2. The PDL contains a wide range of generic and preferred brand name products approved by the FDA.

    3. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.

C. Prior authorizations for non-preferred drugs may be approved for medically accepted indications when criteria has been met.

D. Drugs must be prescribed and dispensed in accordance with medically accepted indications

for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs still in clinical trials and/or investigative or experimental in nature.

E. Prior authorizations are reviewed and a determination notice provided within twenty-four (24) hours from receipt of request. If a PA is not available, a seventy-two (72) hour emergency supply must be dispensed. Pharmacists should use his/her professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is used. The seventy-two (72) hour emergency procedure must not be used for routine and continuous overrides.

F. The PDL is subject to change. Refer to the Division of Medicaid's website for a current listing of prescription drugs on the PDL.

Source: Miss. Code Ann § 43-13-121; Section 127 Social Security Act

History: Eff. July 1, 2012

Part 214 Chapter 2: Pharmacy Disease Management

Rule 2.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists participating in the Medicaid program and providing disease management services must comply with the requirements outlined in Part 214, Chapter 1, Rule 1.1 in addition to the following requirements:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Copy of current pharmacist's license or permit,

3. Current certificate for disease management,

4. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name on the W-9, and

5. Credentials from the National Institute for Standards in Pharmacists Credentialing for the specific disease for which care is provided.

B. Pharmacy disease management provider agreements will not be initiated or maintained with any pharmacist whose place of business is physically located more than thirty (30) miles from the borders of Mississippi.

C. Only individual pharmacists can enroll as a pharmacy disease management provider. Pharmacies with multiple individual pharmacy disease management providers may apply for group management services under one (1) group provider number; but each individual pharmacist in the group must maintain his/her own individual provider number. Businesses such as partnerships and corporations are not allowed to operate as pharmacy disease management providers.

Source: Miss. Code Ann. § 43-13-121, 42 CFR 455, Subpart E

Rule 2.2: Program Services

A. Pharmacy Disease Management (PDM) services are those provided for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anti-coagulation therapy, or other disease states as defined by the Division of Medicaid. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcomes.

B. A referral for PDM services is required and services must be provided by a specially credentialed pharmacist. Pharmacy care records including a written referral and all laboratory test results must be transferred from the referring physician to the pharmacist. PDM services performed by the pharmacist must not duplicate services provided by the physician.

C. The pharmacist must be knowledgeable about pharmaceutical products and the design of therapeutic approaches that are safe, effective, and cost-efficient for patient outcomes. He or she is to function in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. It is the responsibility of the pharmacist to:

1. Evaluate the patient,

2. Consult with the physician concerning the suggested/prescribed drug therapy,

3. Counsel the patient regarding compliance, and

4. Provide the patient with educational and informational materials specific to the disease and/or drug.

D. Communication is required between the referring physician and the pharmacist. Pharmacy disease management services follow a protocol developed between the pharmacist and patient's physician.

E. The pharmacist provider must personally render all pharmacy disease management services billed to Medicaid. A relief pharmacist employed for pharmacy disease management services must bill Mississippi Medicaid using his/her own individual Medicaid provider number.

Source: Miss. Code Ann. § 43-13-121

Rule 2.3: Components of Pharmacy Disease Management

A. The primary components of this service are as follows:

1. Patient evaluation,

2. Compliance assessment,

3. Drug therapy review,

4. Disease state management, according to clinical practice guidelines, and

5. Patient/caregiver education.

B. The pharmacist must provide a separate, distinct area conducive to privacy for a seated, face-to-face consultation with the beneficiary, such as a partitioned booth or a private room. This consultation is used to privately educate the beneficiary.

C. A copy of the pharmacy care records, including the documentation for services, must be shared with the patient's physician and remain on file in the pharmacist's facility and available for audit by the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121

Rule 2.4: Eligibility

A. Pharmacy disease management services are not covered for beneficiaries in long term care facilities or for beneficiaries receiving home health services.

B. Neither OBRA-mandated counseling nor JCAHO-mandated institutional discharge counseling qualify as a pharmacy disease management service.

C. Pharmacy disease management services are available to the parent or other responsible guardian when the beneficiary is a minor and/or mentally challenged and living at home.

Source: Miss. Code Ann. § 43-13-121

Rule 2.5: Reimbursement

A. Pharmacy disease management services are reimbursed on a per encounter basis. When billing for an encounter, pharmacy disease management providers must use the appropriate procedure code. An encounter must be at least fifteen (15) minutes and average thirty (30) minutes.

B. The number of encounters is limited to twelve (12) per beneficiary per fiscal year.

Source: Miss. Code Ann. § 43-12-121

Rule 2.6: Pharmacy Disease Management Documentation Requirements

In addition to the documentation requirements applicable to all pharmacy providers, pharmacy disease management providers must maintain additional documentation. The disease management pharmacist must maintain at his/her place of business proof of current certification for the specific disease state for which reimbursement is sought. A pharmaceutical care record, or patient record, must be maintained on each individual beneficiary for whom services are billed. These records must be retained and maintained in a manner conducive to audit, in alphabetical order and for a minimum of five (5) years. At a minimum, the following documents must be maintained, in date order, within each individual beneficiary's pharmaceutical care record:

A. A referral from the beneficiary's physician/nurse practitioner,

B. A copy of the protocol in accordance with the National Clinical Practice Guidelines authorizing pharmacy disease management of the beneficiary,

C. Documentation of all oral and written communication with the beneficiary's physician/nurse,

D. Copies of all laboratory data provided, and

E. All pharmacist notes, including progress reports, pertaining to the care of the beneficiary.

Source: Miss. Code Ann. § 43-13-117, 43-13-118, 43-13-121, 43-13-129

Title 23: Division of Medicaid

Part 214: Pharmacy Services

Part 214 Chapter 1: General Pharmacy

Rule 1.1: Provider Enrollment and Pharmacy Participation

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2. Drugs when used to promote fertility are excluded,

3. Drugs when used for cosmetic purposes or hair growth are excluded,

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5. Drugs when used for the symptomatic relief of cough and colds,

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2. Less the applicable co-payment of three dollars ($3.00).

G. Medicaid reimbursement methodology for covered over-the-counter (OTC) drugs is:

1. The lesser of:

a) The usual and customary charge, or

b) The estimated shelf price and a dispensing fee of three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines estimated shelf price as the lowest of the following:

a) Mississippi Estimated Acquisition Cost (MEAC) for OTC drugs is defined as the Average Wholesale Price (AWP) less twenty five percent (25%), or

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I. Pharmacists in the legal employ of the pharmacy provider or under the personal direction of a pharmacist employed by the pharmacy provider must submit claims for services rendered. Prescriptions must be dispensed at the provider's actual physical location of the pharmacy.

J. For purposes of this rule, Medicaid defines a prescribing provider as one who is duly licensed and is acting within the scope of practice of his/her profession according to State law.

K. All non-electronic prescriptions must be written on tamper-resistant pads/paper in order to be eligible for reimbursement by Medicaid.

1. The tamper-resistant prescription pads/paper requirement applies to all Medicaid prescribing providers including physicians, dentists, optometrists, nurse practitioners and other providers who prescribe outpatient drugs including over-the-counter drugs.

2. Exemptions to this mandate include:

   a) Prescriptions presented by other modes of transmission including facsimile, electronic or e-prescribed, and telephone,

   b) Written orders prepared in an institutional setting, including intermediate care facilities and nursing facilities, provided that the beneficiary never has the opportunity to handle the written order and the order is given by licensed staff directly to the dispensing pharmacy, or

   c) Transfer of a prescription between two (2) pharmacies, provided that the receiving pharmacy is able to confirm by facsimile or telephone call the authenticity of the tamper-resistant prescription with the original pharmacy.

L. The pharmacy provider must ensure the integrity of telephone, electronic and/or faxed prescriptions.

M. All Medicaid beneficiaries are limited to five (5) prescriptions per month, including refills, with no more than two (2) being brand name drugs, unless provided through expanded EPSDT services in Part 223, Chapter 1, Rule 1.7 or to long-term care residents.

N. Medicaid requires that all drugs be prescribed in a full month's supply which may not exceed a thirty one (31) day supply. The following exceptions are allowed:

1. Drugs in therapeutic classes commonly prescribed for less than a month's supply including, but not limited to, antibiotics and analgesics,

2. Drugs that, in the prescribing provider's professional judgment, are not clinically appropriate for the beneficiary to be dispensed in a month's supply,

3. Drug products where the only available package size of the product is one that exceeds the thirty one (31) day supply limit,

4. Certain drugs issued by the Mississippi Department of Health (MSDH) and approved by Medicaid, including, but not limited to:

   a) Contraceptives which may be dispensed in a one (1) year supply.

   b) Tuberculosis (TB) medications which may be dispensed in a three (3) month supply.

5. Six (6) vials, sixty (60) ml each, of insulin may be dispensed at one time,

6. Oral contraceptives may be dispensed in three (3) month supplies,

7. Prenatal vitamins may be dispensed in three (3) month supplies,

8. Those products with cumulative maximum daily and/or monthly units as recommended by the Food and Drug Administration (FDA) and the manufacturer, and/or as recommended by the Drug Utilization Board and approved by Medicaid,

9. Those products limited by authority of Medicaid with the potential for misuse, abuse, or diversion for the public safety, well-being and/or health, or

10. A limited listing of maintenance medications, approved by Medicaid, which may be dispensed in no more than a ninety (90) day supply.

O. In emergency situations, Medicaid will reimburse for a seventy two (72) hour supply of drugs that require prior authorization.

P. Pharmacy claims must be billed using the National Drug Code (NDC) number of the product dispensed. Pharmacy providers must bill the eleven (11) digit NDC for the drug and package size actually dispensed. This requirement is for all products, regardless of legend or over-the-counter (OTC) status.

Source: Miss. Code Ann. § 43-13-121; § 73-21-115; 42 USC 1396b (i) (21) and (23); 42 USC 1396br-8(a) and (d); 42 USC 1903(i)(23); Social Security Act,

Rule 1.7: Refills/Renewals of Prescription Drugs

G. A written, faxed, e-prescribed, or telephoned prescription may be refilled, in compliance with the prescriber's order, up to a limit of eleven (11) times per year, if compliant with state and/or federal regulations and guidelines. Additionally, the following are applicable:

1. The absence of an indication to refill by the prescribing provider renders the prescription non-refillable.

2. Refills are reimbursable only if specifically authorized by the prescribing provider.

3. Medicaid does not reimburse for prescription refills that exceed the specific number authorized by the prescribing provider.

4. Medicaid does not reimburse for any refills dispensed after one (1) year from the date of the original prescription.

5. Medicaid does not reimburse for a prescription refill with greater frequency than the approximate interval of time that the dosage regimen of the prescription would indicate, unless extenuating circumstances are documented which would justify the shorter interval of time before the refilling of the prescription.

6. Medicaid does not reimburse for quantities in excess of the prescribing provider's

authorization.

H. Medicaid does not reimburse for any refill without an explicit request from a beneficiary or the beneficiary's responsible party, such as a caregiver, for each filling event. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

I. Medicaid beneficiaries or providers cannot waive the explicit refill request and enroll beneficiaries in an electronic automatic refill in pharmacies.

J. Medicaid does not reimburse for a prescription refill until seventy five percent (75%) of the day's supply of the drug has elapsed as indicated on the prescription.

1. For any controlled substance (Schedule III, IV, and V), Medicaid does not reimburse for a prescription refill until eighty five percent (85%) of the day's supply of the drug has elapsed as indicated on the prescription. Any attempt to refill a prescription through the Point-of-Sale system before the twenty-sixth (26^{th}) day will be automatically denied.

2. By law, Schedule II narcotics cannot be refilled.

K. As long as the monthly service limits have not been exhausted, Medicaid may permit an early refill of an original claim under one (1) of the following circumstances:

1. The client's life is at risk,

2. When an acute clinical condition is occurring, which would require extra medication to stop or mitigate further morbidity, or

3. The prescribing provider either increases the dosing frequency or increases the number of tablets per dose. The prescribing provider must document the change in dosage or frequency by writing or phoning in a new prescription. The prescriber(s) who wrote the original prescription must initiate any request for additional medication.

L. Medicaid does not generally reimburse for replacement of prescriptions that are lost, stolen or otherwise destroyed.

1. Replacement of prescriptions is the beneficiary's responsibility.

2. If a beneficiary requires an early refill, the prescribing provider must request an exception override of this requirement by seeking approval from Medicaid's Pharmacy Bureau Prior Authorization (PA) Unit.

Source: Miss. Code Ann. § 43-13-121

Rule 1.8: Generic Mandates for Prescription Drugs

Mississippi law requires that Medicaid does not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive.

A. Generic drugs classified as non-preferred by Medicaid require prior authorization.

B. In the absence of a specific request for the brand name drug from the prescribing provider to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent unless the branded agent is preferred and the generic agent is non-preferred.

C. Prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except Narrow Therapeutic Index (NTI) drugs as defined by Medicaid.

Source: Miss. Code Ann. § 43-13-117; § 73-21-115; 73-21-117; 73-21-123; 73-21-127; 73-21-129

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Preferred Drug List

A. The Division of Medicaid recommends that prescribers use the drugs on the Preferred Drug List (PDL).

1. The PDL is defined as a list of drugs reviewed and proposed by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, nurse practitioners, and/or other health care professionals. Final approval of the PDL is the responsibility of the Executive Director of the Division of Medicaid.

2. The PDL contains a wide range of generic and preferred brand name products approved by the FDA.

3. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.

4. ~~The Division of Medicaid does not reimburse for brand name drugs if there are equally effective generic equivalents available and the generic equivalents are the least expensive.~~

I. ~~The Pharmacy Benefits Manager approve drugs outside the PDL when one (1) of the following prior authorization (PA) criteria is satisfied:~~ Prior authorizations for non-preferred drugs may be approved for medically accepted indications when criteria has been met.

1. ~~Beneficiary must have used the preferred agents for at least a thirty (30) day course of treatment per drug and failed trials within six (6) months prior to requesting the PA and there is documentation of therapeutic failure of preferred drugs,~~

2. ~~Adverse event(s) reaction(s) to preferred agents, or~~

3. ~~Contraindications to preferred agent(s), such as drug interaction or existing medical condition preventing the use of preferred agent(s).~~

J. ~~Exceptions to the PA criteria in Rule 1.10, B. 1, 2, 3, may be considered if there is sufficient documentation of stable therapy as reflected in ninety (90) days of paid Medicaid claims.~~

K. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs still in clinical trials and/or investigative or experimental in nature.

L. ~~PDL exception request will~~ Prior authorizations are reviewed and a determination notice provided within twenty-four (24) hours from receipt of request. ~~by telephone or other telecommunication devices. In emergency situations, the Division will allow payment for a seventy-two (72) hour supply of drugs~~ If a PA is not available, a seventy-two (72) hour emergency supply must be dispensed. Pharmacists should use his/her professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is used. The seventy-two (72) hour emergency procedure must not be used for routine and continuous overrides.

M. The PDL is subject to change. Refer to the Division of Medicaid's website for a current listing of prescription drugs on the PDL.

Source: Miss. Code Ann § 43-13-121; Section 127 Social Security Act

History: Eff. July 1, 2012

Part 214 Chapter 2: Pharmacy Disease Management

Rule 2.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists participating in the Medicaid program and providing disease management services must comply with the requirements outlined in Part 214, Chapter 1, Rule 1.1 in addition to the following requirements:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Copy of current pharmacist's license or permit,

3. Current certificate for disease management,

4. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name on the W-9, and

5. Credentials from the National Institute for Standards in Pharmacists Credentialing for the specific disease for which care is provided.

B. Pharmacy disease management provider agreements will not be initiated or maintained with any pharmacist whose place of business is physically located more than thirty (30) miles from the borders of Mississippi.

C. Only individual pharmacists can enroll as a pharmacy disease management provider. Pharmacies with multiple individual pharmacy disease management providers may apply for group management services under one (1) group provider number; but each individual pharmacist in the group must maintain his/her own individual provider number. Businesses such as partnerships and corporations are not allowed to operate as pharmacy disease management providers.

Source: Miss. Code Ann. § 43-13-121, 42 CFR 455, Subpart E

Rule 2.2: Program Services

A. Pharmacy Disease Management (PDM) services are those provided for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anti-coagulation therapy, or other disease states as defined by the Division of Medicaid. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcomes.

B. A referral for PDM services is required and services must be provided by a specially credentialed pharmacist. Pharmacy care records including a written referral and all laboratory test results must be transferred from the referring physician to the pharmacist. PDM services performed by the pharmacist must not duplicate services provided by the physician.

C. The pharmacist must be knowledgeable about pharmaceutical products and the design of therapeutic approaches that are safe, effective, and cost-efficient for patient outcomes. He or she is to function in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. It is the responsibility of the pharmacist to:

1. Evaluate the patient,

2. Consult with the physician concerning the suggested/prescribed drug therapy,

3. Counsel the patient regarding compliance, and

4. Provide the patient with educational and informational materials specific to the disease and/or drug.

D. Communication is required between the referring physician and the pharmacist. Pharmacy disease management services follow a protocol developed between the pharmacist and patient's physician.

E. The pharmacist provider must personally render all pharmacy disease management services billed to Medicaid. A relief pharmacist employed for pharmacy disease management services must bill Mississippi Medicaid using his/her own individual Medicaid provider number.

Source: Miss. Code Ann. § 43-13-121

Rule 2.3: Components of Pharmacy Disease Management

A. The primary components of this service are as follows:

1. Patient evaluation,

2. Compliance assessment,

3. Drug therapy review,

4. Disease state management, according to clinical practice guidelines, and

5. Patient/caregiver education.

B. The pharmacist must provide a separate, distinct area conducive to privacy for a seated, face-to-face consultation with the beneficiary, such as a partitioned booth or a private room. This consultation is used to privately educate the beneficiary.

C. A copy of the pharmacy care records, including the documentation for services, must be shared with the patient's physician and remain on file in the pharmacist's facility and available for audit by the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121

Rule 2.4: Eligibility

A. Pharmacy disease management services are not covered for beneficiaries in long term care facilities or for beneficiaries receiving home health services.

B. Neither OBRA-mandated counseling nor JCAHO-mandated institutional discharge counseling qualify as a pharmacy disease management service.

C. Pharmacy disease management services are available to the parent or other responsible guardian when the beneficiary is a minor and/or mentally challenged and living at home.

Source: Miss. Code Ann. § 43-13-121

Rule 2.5: Reimbursement

A. Pharmacy disease management services are reimbursed on a per encounter basis. When billing for an encounter, pharmacy disease management providers must use the appropriate procedure code. An encounter must be at least fifteen (15) minutes and average thirty (30) minutes.

B. The number of encounters is limited to twelve (12) per beneficiary per fiscal year.

Source: Miss. Code Ann. § 43-12-121

Rule 2.6: Pharmacy Disease Management Documentation Requirements

In addition to the documentation requirements applicable to all pharmacy providers, pharmacy disease management providers must maintain additional documentation. The disease management pharmacist must maintain at his/her place of business proof of current certification for the specific disease state for which reimbursement is sought. A pharmaceutical care record, or patient record, must be maintained on each individual beneficiary for whom services are billed. These records must be retained and maintained in a manner conducive to audit, in alphabetical order and for a minimum of five (5) years. At a minimum, the following documents must be maintained, in date order, within each individual beneficiary's pharmaceutical care record:

A. A referral from the beneficiary's physician/nurse practitioner,

B. A copy of the protocol in accordance with the National Clinical Practice Guidelines authorizing pharmacy disease management of the beneficiary,

C. Documentation of all oral and written communication with the beneficiary's physician/nurse,

D. Copies of all laboratory data provided, and

E. All pharmacist notes, including progress reports, pertaining to the care of the beneficiary.

Source: Miss. Code Ann. § 43-13-117, 43-13-118, 43-13-121, 43-13-129